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Hollowing out national agreements in the NHS? The case of 'Improving Working Lives' under a 'Turnaround' plan

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Introduction

This article evaluates the employment relations impact of implementing two distinct – and separate – policies, with seemingly conflicting agendas, in an NHS hospital. The NHS has long claimed to aspire to be a 'model employer' (Bach, 2005; 2010; Corby and Symon, 2012; Morgan and Allington, 2002) and this has been manifested at the level of the individual employment relationship between employer and the public service professional (Lethbridge, 2011; Needham, 2007), at workplace level (Stuart and Martinez Lucio, 2000) and national levels, where Whitley structures have largely remained as the basis for establishing pay grading levels (Bach and Kessler, 2012). However, there has been little recognition of the tensions that can exist when agendas at each level are seemingly incompatible: incompatibilities between local and national priorities, for example.

This article reports on a case study exploring the resilience of mutual–gains initiatives aimed at employee welfare in an NHS hospital under financial pressure. In particular it considers the tensions created in the implementation of the national-level *Improving Working Lives* (IWL) initiative in the hospital following the localised introduction of another initiative: 'Turnaround'. The article considers the extent to which these separate agendas were compatible and, where not compatible, with what consequences – in particular, at the individual level of the professional autonomy of the public service professional.

This article addresses the following research questions. First, during a period of crisis, to what extent do national-level integrative employment relations' agreements become subordinate to local-level financial imperatives? Second, where there is incompatibility,

what are the outcomes in terms of the impact on individual working conditions – in relation to aspects of the IWL agenda?

The study is based on events occurring at a hospital between 2007 and 2009. While the specific detail of structural reform in this study is based on policy agendas stemming from the 1997-2010 Labour administrations, there is continuity with the scenario post-2010 in that that performance-driven reforms at the organisational-level coexist with national-level agreements on terms and conditions of employment. The case study contains exactly the tensions in local/national policy initiatives relating to employment as is the case in the devolved 'commissioning' structure of the NHS contained in the Health and Social Care Act 2012 and certain to continue following the election of a majority Conservative government in 2015 and with it the continuation of NHS financial uncertainty, the implications of the Trade Union Act 2016 and the consequences of the 'Brexit' referendum.

The article proceeds as follows. First, IWL, as a mutual-gains employment relations initiative will be outlined and considered within the context of the NHS as 'a model employer'. Second, the introduction of '*Turnaround*' as part of a broader performance-based reform agenda will be explained. The development of these sub-systems of employment relations in the NHS will then be considered, raising the question as to whether they exist in parallel or in sequence. The hybrid model developed by Bach and Kessler will be outlined as a possible approach to viewing the co-existence of IWL and Turnaround. The case study hospital and methodology for this study will then be outlined before presenting findings. The concluding section will then consider the implications of the apparently clashing demands of IWL and Turnaround when operating simultaneously and consider what this means for our understanding of a dualist employment relations system in the NHS.

IWL as Model Employer Initiative

IWL was launched in the NHS in 1999 as part of the 'staff-side' element of NHS reform (Bach, 2005) and established as a standard in 2001 (DoH, 2000). It is explicitly mentioned as a significant element of 'investing in staff' in the NHS Plan (2000: 53). It was an initiative jointly supported by health service employers and unions with the aim of enhancing working practices to the mutual benefit of staff and patients and was revisited and re-endorsed in 2009.

The notion that improving people's working lives benefits organisational objectives reflects a 'dual agenda' model for managing work and personal life. (Rapoport, *et al* 2002) and links strongly to the narrative of work-life balance. In addition to the general case of work-life balance being a mutual-gains notion, the working lives of healthcare workers is of concern not only to individual workers and their families but also to patient outcomes (Avgar *et al*, 2011; Moonesinghe, *et al* 2011). Finally, there is good evidence to suggest that work-life balance initiatives are more successful when supported by collective bargaining arrangements (Hyman and Summers, 2007; Rigby and O'Brien Smith, 2010).

With these issues in mind, the IWL Standard committed NHS employers to some core principles, including that "*staff work best for patients when they can strike a healthy balance between work and other aspects of their lives outside work*" (p13), that employers "*accept joint responsibility with staff to develop a range of working arrangements that balance the needs of patients and services with the needs of staff*" (p14), and that "*values and supports staff according to the contribution they make to patient care and meeting service needs and*

by provid[ing] *personal and professional development and training opportunities that are accessible and open to all staff irrespective of their working patterns*" (p16).

However, some studies have indicated problems in implementation. Skinner et al (2004), based on survey evidence, report that there is a gap between the intensions within IWL and the perceived practice among NHS workers, leading to a breach of trust between management and workers. They do not, however, identify what – beyond broader issues of reform-induced turbulence – the source of the implementation gap is. To identify the possible sources IWL needs to be considered in the context of being at the interface of two levels. First IWL operates at the *individual* level of the worker navigating the relationship between their domestic responsibilities with the demands of their employer. At the *institutional* level, IWL operates within the employment relations structure of the NHS.

The operational context in which any understanding of IWL as nationally-driven initiative would need to be made, is within the broader narrative of the NHS as a 'model employer'. From the inception of the NHS, the content of the 'model employer', was that of Whitley pay structures determined by national-level collective bargaining and benchmarked to 'appropriate' private sector comparators, equitable recruitment and promotion processes, transparent grievance procedures, pensions and high job security (Corby and Symon, 2012; Hepple, 1982; Morris, 2000). It has been argued that the most recent articulation of the model employer would also necessarily include a commitment to equality and diversity (Corby, 2007; Corby and Simon, *op cit*)

There is some evidence that elements of the model employer have been eroded across the public sector in the UK since the 1980s - especially in relation to job security (Morgan and

Allington, 2002) – and this is linked to the agenda of reform that is discussed, below. There are some that argue that the model employer has largely been a myth, when judged on substantive outcomes rather than just the issue of procedural justice (Coffey and Thornley, 2009), though Stuart and Martinez Lucio (2000) argue that the model employer has retained some traction in the NHS, when compared to private sector employer-union partnership arrangements, particularly when considering the issues of communication and 'family-friendly policies'. Overall, the model employer has nevertheless remained an important narrative – if not a heuristic - for employment relations in the public sector (Bach, 2010). The issue is the extent to which distributive outcomes match the procedural principles and aspirations.

Turnaround as Upstream Performance Management Initiative

It is the coexistence of IWL, within the broader context of NHS reform, that the parallel process of *Turnaround* is now considered. Turnaround comes from an entirely different place to that of IWL. The issue of financial accountability within the NHS has always been an issue. However, the specific mechanisms by which the financial performance of individual hospitals were to be measured began to change from the 1980s in line with the broader ideological challenge from what is now commonly labelled neoliberalism, but at the time identified more as a nascent 'new right' challenge to the role, structure and delivery of welfare in society (Clarke and Newman, 1997). The introduction of quasi-markets, cost centres and key aspects of performance management could not have been achieved without reforms to the financial accountability structure of the NHS. The introduction of Foundation Trust status, from 2002, provided a further catalyst for greater attention being paid to hospitals being more financially self-sufficient. To this end the Wanless (2002) and

Douglas (2006) reports created an environment in which hospitals could be deemed to be in need of short-term intervention by a designated 'Turnaround' team to make organisational changes necessary to balance the books.

The concept of *Turnaround* originates in the US management discourse to refer to a management and organisational tool of intervention in an organisation experiencing (usually) financial crisis and establishing processes and procedures to restore financial stability. In the US it was used for profit-based organisations and then applied to hospitals (Rindler 1987). The general principle of *Turnaround* is to 'rescue' the organisation from long term decline. Decline is deemed to be caused by a combination of a drift in strategic direction and inertia in being able to make bold changes to tackle cost overrun (Hofer, 1980). The process is generally accepted to involve a period of rapid retrenchment, followed by a period of 'recovery' (Robbins and Pearce, 1992).

Beeri (2012) notes that *Turnaround* initiatives distinguish themselves from ordinary change management initiatives in that they are always associated with radical organisational change; that they are invariably urgent; that they are likely to be under intense scrutiny; that they are executed by either 'poor', 'new' or 'enthusiastic' management; that they face resistance from stakeholders leading to deteriorating morale.

In all of this the transfer of *Turnaround* from corporate private sector – where the success criteria is predominantly measured in terms of shareholder value - into the NHS, is not considered problematic. Some criticism has been made of how using *Turnaround* in the context of a public service is 'shock therapy' aimed at stigmatisation of communities being served and as a Trojan horse for privatisation (Walker Johnson, 2012). In the NHS context,

there is evidence of some disquiet about the make-up of *Turnaround* teams including criticism from nurses' unions (Nursing Standard, 2005)

In common with processes in other public services, a first stage of *Turnaround* is the identification of 'the problem'. To do this an external inspection regime was introduced. Hospitals were to be awarded with a star rating to indicate performance against key targets set by the Government. Zero stars would be awarded for the poorest level of performance and three stars for the highest. Performance Development Teams were formed in June 2003 as part of the NHS Modernisation Agency to offer support to zero star Trusts and worked with all NHS organisations that received a zero-star performance rating to promote and facilitate organisational *Turnaround*. In July 2003, 42 NHS Trusts received a zero-star performance rating, compared to 12 in the previous year when primary care Trusts were not included in the ratings (Harvey et al 2005). The Star Performance criteria was replaced in 2005 by Annual Health checks based on two criteria – financial and quality. In this time the Department of Health contracted *Turnaround* teams to review 98 NHS bodies faced with financial difficulties. Evidence regarding the impact of Turnaround is mixed. The then Chief Executive of the NHS, David Nicholson, in his submission to the Select Committee on Health (2008/09) stated that *Turnaround* teams had moved hospitals from a deficit to a surplus (HoC, 2008). To be sure, the role of *Turnaround* teams was seen as positive in terms of providing external support to hospitals experiencing financial difficulties and coping with management and organisational changes (Harvey et al 2005). On the other hand the protracted financial uncertainty facing the NHS places a number of questions regarding how far Turnaround has resolved some of the basic structural problems experienced by Trusts. For example, the Kings Fund (2006) has stated that the cause of financial deficits are

complex and can also be related to national policies and meeting national targets as well as the consequences of constant reorganisation and changes in performance targets. Furthermore, Turnaround has been seen as the 'sole preserve of the financial function' where interventions are overly focused on 'balancing the books' (Shields, 2013) and that a longer time line is required where change is generated from 'within' (Ham, 2014: 56).

Turnaround, as a specific measure to be used in specific circumstances, needs to be seen in the wider context of how it fits within the broader public service reform agenda associated with public choice theory (van den Berg, 2004). As a logical extension of public choice interpretations of the dysfunctions of the public sector that so influenced the Conservative governments' reform agenda from the 1980s (Gamble, 1994) there was an accompanying hostility to the prevailing public sector employment model itself – including its model employer aspiration. This was the period that saw the rise of new public management (NPM) (Hood, 1991) or, more pejoratively, of 'managerialism' (Clarke and Newman, 1997; Pollitt and Bouckaert, 2011). In terms of workplace relationships, it became fashionable to denounce the idea of the NHS as a single employer, attempting to achieve its objectives through the use of traditional models of the open-ended employment relationship and based on the reliance on the public service ethos motivating professional staff withn the service. Instead a whole series of reforms introduced a more devolved structure making use of internal 'quasi markets', coupled with a greater use of centralised performance targets, to shift the emphasis for the control of labour to one of a principal-agent problem informed by agency theory (LeGrand, 1999) This way, patient outcomes could be improved by reducing the undue influence of professional demarcation and union influence seen to be obstructing change. The assumption, in agency-theory inspired NPM, of zero-sum

relationships existing between managers, workers and patients is in marked contrast to the integrative (Walton and McKersie, 1985) relationships suggested in IWL.

NHS Employment Relations: parallel or sequential systems?

From the outline of IWL and Turnaround, above, there appear to be two narratives operating simultaneously but in isolation from each other. Turnaround operates within the narrative of NPM, while IWL is best seen in context of the ideal of the 'model employer'. While the notion of the model employer remained as a residual concept, its legitimacy began to be openly challenged after 1979. We now consider the inter-relationship between NPM and the model employer.

After 1997, the incoming Labour government augmented the inherited public service reform project through an emphasis on 'partnership' between employers and unions (Johnstone *et al* 2009). This arrangement sought to re-establish the *heuristic* of the model employer, while retaining the 'performance' features established in NPM. The origins and purposes of these distinct narratives – model employer/partnership on the one hand; NPM/performance on the other - is not an easy coexistence, but coexist, they did nonetheless. For example, the *Agenda for Change* pay restructuring between 2004 and 2009 constituted a renewed attempt to introduce greater transparency in job categories linked to national pay grading. On the other hand, after initially fulfilling election pledges to abandon internal market restructuring of the NHS, the New Labour approach then reverted back to embrace further NPM-inspired reforms harnessing the language of markets, customers, choice and flexibility in the restructuring of workplace-level relationships. This saw an increase in external involvement through the Private Finance Initiative (PFI) leading to new

forms of workplace regulation. The coexistence of national employment relations structures simultaneously with the encouragement of a more localised organisation-level work regime (numerical and functional flexibility, performance management) creates a dilemma.

Bach and Kollins-Givan (2012) illustrate one outcome of this scenario whereby the Private Finance Initiative in the NHS has led to a de-facto 're-regulation' of workplace relationships. Here, aspects of employee rights previously assimilated in general terms into the employment relations system became conditions of contracts. However, while this offers a useful parallel in comparing the potential for how a third party becoming involved with the running of a public hospital could result in a de-facto 're-regulation' of employment relations, it is not directly comparable where the PFI model – as long-term contract relationship - does not apply. It is possible to conceptualise the emergent hybridised system as being the product of wider systemic change; either evolutionary or periodic. Prominent models of periodic change in management ideologies are available. Barley and Kunda's (1992) is one such model based on their study of US management paradigms. In this model, 'normative' and 'rational' dominant managerial ideologies alternate over long time periods linked to long wave technological/economic cycles associated with periods of labour activity. This model is not dissimilar to Ramsay's (1977) UK model of cycles of the managerial promotion of employee participation (again) being linked to the fluctuating strengths of organised labour.

The extent to which such models are replicated in the NHS system being described here is more complex, however. The two initiatives under scrutiny (IWL and Turnaround), and the narratives in which each operates (the Model Employer and NPM, respectively) coexist in

the same overall system at the same time. This could be closer to the more adaptable and inconsistent approach, observed by Esbenshade et al (2016), in the attempted adoption of 'business process re-engineering' into a welfare agency. The question is, are these systems acting in parallel, as a dualist system with different elements coexisting in conflict at the same time, or are they existing in sequence – with one managerial narrative being supplanted with newer narratives.

With this point in mind, a useful model for dealing with the integration of national/local systems is provided in Bach and Kessler's (2012) model of New Labour reform of public sector employment relations – and with a strong part of the model being dedicated to the NHS system in particular. In this model the overall system is characterised as consisting of an upstream public management element converging with a downstream employee relations element. The upstream elements were informed by performance management and quasi-market elements of the NPM narrative, importing methods from the private sector and challenging the notion that public management is inherently different to that of private sector management (Boyne, 2002). The emphasis was on more localised decision-making to achieve nationally-determined performance targets. Turnaround could be considered as an element of upstream performance management under Bach and Kessler's (2012) model.

The downstream element largely consists of the national-level collective bargaining mechanisms and agreements. In turn these downstream elements would incorporate, to use Walton and McKersie's (1985) classical collective bargaining typology, *Agenda for Change* as an example of the distributive bargaining sub-system and IWL as an example of the integrative bargaining sub-system.

However, the nature of this upstream/downstream, national/local tension is significant, as it is within this context – originating from national-level structures; implemented within localised organisational pressures - that the implementation of IWL must be seen. Into this mix is the specific element of the reform agenda relating to the financial performance of hospitals.

To reiterate, the research questions that will be addressed are, first, during a period of crisis, to what extent do national-level integrative employment relations' agreements become subordinate to local-level financial imperatives and, second, where there is incompatibility, what are the outcomes in terms of the impact on individual working conditions – in relation to aspects of the IWL agenda?

Case study and methodology

To address these questions this article examines how the competing upstream/downstream agendas of IWL and Turnaround play out within a specific hospital context, and what the consequences are for individual working life (Bazen et al, 2005; Gallie, 2007; Green, 2006).

This article draws on research from a larger multi-workplace EU study of the 'quality of work and life in a changing Europe'. Case studies were carried out with the objective of examining the potential dual agenda of support for quality of working life, particularly work-life balance and workplace effectiveness. The case study discussed here was conducted between 2007 and 2009 at a London NHS hospital. At the time when fieldwork commenced, the case-study hospital was in crisis, responding to proposals contained in a government report on the NHS in London, inspired by Douglas (2006) on financial autonomy and

accountability. This led to a local *Turnaround* initiative being imposed, from 2006, whereby management consultants were sent into the hospital to impose efficiency changes.

There had been two *Turnaround* plans for this hospital in 2006/07 and 2007/08. Following a period of expansion the financial position of the hospital was £27.3 million in deficit. The main changes in the *Turnaround* process involved vacancy control and a freeze in certain areas of expenditure. Over 200 staff were lost through voluntary and compulsory redundancy measures, wards were closed and tight control was imposed over the use of agency staff for short-term cover.

The initial fieldwork, in 2007/8, was therefore undertaken at a time of considerable change and uncertainty; not only about the impact on employment, but also the future status of the hospital itself. At the earliest stage, the research objectives were to explore current and future expectations of working life - linked to IWL - and their impact on the dual agenda of employees' quality of life and workplace effectiveness. However, as initial interviews revealed the significance of financial constraints, *Turnaround* and organisational restructuring, research objectives were expanded to incorporate the relative significance of this emergent theme.

Semi structured interviews were conducted with twenty four people: eleven managers (including the designated IWL coordinator), six nursing staff, four doctors (including a BMA representative), and one from administrative staff. In addition one full-time workplace representative each from Unite and UNISON, both members of the joint consultative committee, were also interviewed. Interviewees were asked about their experiences of past, present work and thoughts about the future, what the main challenges were and how this

affected work effectiveness and quality of life. Interviews were approximately one hour in duration and interviewees participated on the basis of *informed consent*. All names used, below, are pseudonyms to protect the identity of interviewees. Interviews were recorded and transcribed verbatim and transcripts were thematically analysed (Braun and Clarke 2006). A synopsis of each interview transcript was read by all authors and subsequent discussion identified broad themes.

Findings

Findings are presented around three broad themes informed by the IWL standard, and emerging from interviewees' own expressed priorities in order to identify how the competing agendas (IWL and Turnaround) affect the quality of working life for a range of workers at the hospital. The emergent themes are (a) the change process involved in introducing Turnaround and the associated employee voice mechanisms used to facilitate these changes, (b) the impact of Turnaround on time autonomy and self-rostering and (c) work pace and intensity as a consequence of the outcomes of the above themes.

Turnaround, the change process and employee voice

The first theme, partly envisaged in the original conception, but emerging as a more prominent theme as a result of *Turnaround*, was that of voice. Voice was defined as individual employee involvement and collective employee participation in decision-making during the changes being introduced. One of the principles in IWL is that of a high trust mutual gains exercise between management, staff and unions. With this in mind, the changes envisaged in *Turnaround* were always going to be challenging. The process of staff involvement and participation was therefore important. From the outset, however,

tensions were reported about the appointed head of Turnaround, whose management style was somewhat confrontational. 'Doreen', an Assistant Director reported that she "…*was managed by the Turnaround Director, which was probably the worst 8 or 9 months of my life so far in an organisation*". Another manager reported that "…e*veryone hated him. He was a bully and I think even the Chief Exec at the very end of the whole process just wished he would go".* The same interviewee reported that the ensuing turbulence saw

> *…a vast array of directors and assistant directors and interim directors. They have all come in with their own vision, their own focus and that doesn't help… We're onto our third … Finance Director.* (Jacqui, Project Manager)

All of this turbulence did not help to establish trust in persuading staff that the change management process would be done in a way that was likely to be compatible to their established working patterns:

> *There are good change agents and there are bad ones…* [H]*e was from the private sector so* […] *he didn't understand the concept and the governance around health. He came in with this idea that change could happen overnight almost: if you really wanted it to, you could stop something today, implement something new tomorrow and everyone should just fall in line. It's not how the Health Service works, unfortunately.* (Jacqui, Project Manager)

The hospital, in common with established NHS practice, recognised the major trade unions and the their official employee relations policy placed "...*emphasis on effective consultation with staff and their representatives as appropriate,*(and)*recognition of the importance of positive communication with staff and their involvement at the earliest possible stage in the*

process of change to reduce anxiety and maintain morale" (HR Policy Handbook). In spite of this, unions perceived consultation to be undermined by actual practice:

> [closing a ward] *was traumatic and handled very badly. Literally a whole raft of middle managers came in and said – we are closing this afternoon… The nurses had hardly had time to say goodbye to each other and sort things out. ….What they normally tend to say is that it's a temporary closure so we don't need to consult and then you find that they don't reopen the ward* (Jane, Unison site representative)

In addition, where formal consultation did take place, it was felt to be tokenistic:

> *Even when they do consultations they do a 30 days consultation where they put out a paper and it goes to the unions and to the staff and there's time for comments. You can write comments or you can ask in meetings etc. They always have a meeting with staff – they say put in your response none of the responses work* (Jane, Unison site representative)

This perception was not restricted to the opinions of union branch officers. Interviewees commented across all levels on the perception that *Turnaround* was not an inclusive process:

> *…so the Consultation document came out and we all knew it was happening. We all sent our comments in about what we thought or didn't think, etc. and then the decision was "we're going with what we said originally, there may be these few changes, but on the whole the Consultation happened"* (Doreen, Assistant Director)

They keep saying the same thing but I don't feel they're getting the answers that they want… because why do we keep being consulted? But nothing has changed. I think they'd like a different answer (Caroline, Head of Clinical Support Service)

Other established forms of communication also continued throughout the Turnaround process. Some interviewees saw the IWL team, in-house newspapers and the intranet as illustrations of high commitment by senior management to informing and consulting staff. However there was also suspicion that more informal channels of communication were undermining this. This view that was articulated in different ways:

…you don't know what people are saying is right or wrong and we saw all these posters saying "Save [the hospital]" and I think there should be at least an inset day, where staff can be informed about what's going on (Iris, newly qualified nurse)

*There has been no engagement with staff….. Its always: 'this is what we are going to do and this how we are going to do it' , rather than ask for our suggestions (*Fiona, doctor)

Time autonomy and self rostering

The second theme, the allocation of working time, is a fundamental element within IWL as it relates to a core issue of control over working arrangements for workers. While total worker autonomy over working time could never be complete in an acute healthcare setting, the principle of *dialogue* to ensure equity in the distribution of working-time patterns is essential if IWL is to be credible. In principle, there seemed to be support for this. According to an HR manager "...*team-based self-rostering can... promote more collaborative working*

relationships, effective cooperation and a greater ownership of staffing issues". However, whilst there were reported inconsistencies in how true this was before Turnaround, it became consistently difficult to operate in practice afterwards – primarily as a result of staff redundancies and reorganisation

> *People felt the stress of losing their team and I think that it was something that we found the Trust simply did not appreciate how important working in a team was for staff. Teams had built over a long period of time including the support networks …the informal support networks and the way of working and solving problems. (Jane Unison site representative)*

Following *Turnaround* the reduction in permanent and agency staff undermined the capacity to deliver self-rostering and therefore seemed to directly mitigate against a core principle within IWL.

> *On a ward I have 37 staff. ...I have had three vacancies removed, so that leaves me with 34 .... Out of the 34 staff, I've got three who are clerical posts, so that leaves me with 31 nursing staff. Out of them 31 nursing staff I've got 5 staff who are pregnant at the moment. And then I have 4 unqualified and the rest are qualified and the pregnant ones are qualified staff. Now 17 out of those 31 staff have got children, they are either single parents, or are parents with a partner. What those staff do is put their requests out and I'm having problems at the moment in relation to planning my rota…* (*Adina*, Nursing Manager, female)

Moreover, the *process* of allocating flexible working and rotas were inconsistent. Some interviewees were able to negotiate their work-life balance where there was sympathetic

management and positive working relationships within the work area. However in other work areas – crucially for nursing staff – it was less effective. IWL did provide criteria for prioritising individual circumstances for shift allocation. One nursing manager reported that IWL was consulted when a male nurse made a request on childcare grounds but would have to demonstrate that he was the main carer in order for the request to be granted. Such rationing not only pits working parents against non-working parents. It also undermines the principle that WLB should equalise gender role stereotypes and the inclusive intensions of IWL. The coordinator for IWL, commented that "…*other members of staff are finding that they didn't have child care commitments, were given the odd days that were not wanted because all the other days were taken.*" The resourcing issues necessitated a change in process for acute services. Nurses were required to put forward their desired shift and working hours up to six weeks in advance for a four week rota cycle. This proved disruptive for existing childcare arrangements for some, with all three nurse interviewees expressing discontent with this change. In non-clinical support services, work-life balance arrangements were also not what was expected. In human resources, for example, 'Paula' reported that she had been given exceptional allowance to adjust her working hours by fifteen minutes to allow for childcare arrangements, but that more generally flexitime was opposed by management within the service, on the grounds that it would be 'abused' by staff.

So the staffing constraints imposed by *Turnaround* negatively affected the capacity to deliver self-rostering in the way envisaged by IWL. All the trade union site representatives, managers and administrative staff participating reported that it was common to work more

than contracted hours in order to complete their expected workload, all of which links to the third theme.

Work pace and intensity

The final theme was that broadly encapsulated by participant perceptions of work intensification as indicated by workload within the time constraints of the working day. This is broken down into the issue of presenteeism and the issue of the boundary spillover effects of work into home life resulting in 'work-family conflict' (Bellavia and Frone, 2005). When asked "what is it like to work here?", most expressed high levels of satisfaction to intrinsic workplace factors: to the value of the work they did, to the ethics of universal health care and of collegiality. Mention was made of the general high demands felt by the general existence of performance targets. However, specific mention was made of how *Turnaround intensified this pressure as a consequence of* staff reductions and job insecurity among colleagues:

> *Generally it (the hospital) provides a decent service, although it provides a decent service at the expense of morale amongst the staff who work in it which is not really sustainable. Morale is low. But there is a recognition of that and senior levels is beginning to recognise that is affecting our ability to do our jobs properly and that people don't see a reason to work any more and are beginning not to want to work here any more"* (Graham, doctor).

This manifested itself, in the views expressed by interviewees, through an increase in presenteeism, to negative work-family 'spillover' and 'boundary' effects of 'taking the work home' and to stress-related sickness absence.

Thus, on the sub-theme of presenteeism, the workload, combined with the increased uncertainty on job security, led to increased demands. A particularly manifestation of this, in the case for managers and support functions, was to extend working hours:

> *There was a system that you had to be here around eight to eight-thirty so a lot of times I was struggling with my husband as to bartering who could do that and I would have my son in the evenings and get home at about six-thirty and he would be talking to me on the phone and I'm saying "I know, when I get home I promise I will come and see you, even if you are sleeping"* (Jacqui, Senior manager)

While working above contracted hours was commonly reported among all categories of staff, one interviewee did express a counter-view that much bad practice was as much the result of bad ward-level management and a misinformed definition of public service ethos, as it was a consequence of *Turnaround*:

> *…there's a lot of people who are sort of like slaving away like Florence Nightingale, thinking it's really normal to go home an hour after the end of your shift, which is mindless (Charmaine, Senior Nurse)*

In terms of the boundary-spanning nature of the work into the domestic sphere, there was some comment on the intrinsic reward in much front-line service work. One recently qualified staff nurse commented that "*nursing opened my eyes to a lot of things* [and] *made me a more caring person*". When the effects of Turnaround are considered, however, the spillover is all negative. A frequently expressed complaint was mental exhaustion – combining the feeling of not achieving what was needed to be achieved in the working day

with the fear from the increased insecurity. More than one interviewee considered that stress was often taken home and impacted on family relationships:

> *Yes, they do things like go home, have a bite to eat and go straight to bed. Some people come in on the weekends for a couple of hours – yes in our department they do.*(Michael, Staff Nurse)

In addition:

> *Most of the time it is hospital-home-hospital-home. I have not got any time for a social life any more. Because sometimes I go home very tired. I haven't got any supper, I can't play with* [my child] *because I'm so tired. So sometimes I have two days off and I need to settle my home and cook. I have no social life*. (Angelina, nurse)

All of this feeds into the basic issue that underpinned the original principle of what IWL was supposed to achieve: the positive integrative relationship that can be gained by enhancing work-life balance for staff in an acute public service setting results in a healthier workforce. Turnaround was attributed to the opposite:

> *…come the weekend I'm still thinking about work and thinking about what I'm going to be doing on Monday. I could be on leave but I have to ring in – and I'm not even in a senior post and that's what gets to me* (Paula, HR administrator)

The persistence of these psychological pressures were reported to spillover into sickness absence concerns:

> *If you want to look at morale, ...often related to sickness levels, etc and yes there's genuine sickness but with some, there's exhaustion and I think, you know, that does*

> *worry me slightly in the sense if we are working really hard and not being recognised for it.* (Ros, Consultant Midwife)

Also:

> *… a lot of people have been off with stress for long periods of time and they come back, they're ok for a little while and then it all hots up and then they're off again and it's also with stress that's developed… and I think is a direct result of Turnaround with the cutting of posts. Obviously people don't like having to change…but having to change when there are less people around to support the work that needs to happen – so yes a lot of people have been off sick and are coming back again and going off again*. (Doreen, Manager, Performance Targets)

An interesting finding from the interviews is that union bargaining agendas do not specifically focus on the issue of work quality and work-life balance per se. Unison, for example issues guidelines to trade union branches and shop stewards regarding negotiating flexible working, but this was seen as both difficult to apply within the hospital and not a priority given the need to respond to the more pressing concern of job loss:

> *Obviously our main priority is to deal with requests by staff for representation in relation to specific grievances around a whole range of issues but also our concern has been to ensure that redundancies are avoided and staffing levels are sustainable so that people do not have to be over worked* (Jane Unison Site Representative)

However, workloads were directly linked to staffing levels by the trade unions so it is difficult to see why the trade unions distanced themselves from IWL during the Turnaround

process, given that IWL could have provided a justification to keep staffing levels to a sustainable level in order to prevent work intensification.

Discussion and Conclusions

This article has sought to identify how the processes and outcomes associated with IWL in an NHS hospital are reconciled with the processes and outcomes associated with a *Turnaround* initiative being implemented simultaneously. Specifically it addresses two research questions. First, during a period of financial crisis, it is clear that national-level integrative employment relations' agreements *do* become subordinate to local-level financial imperatives. Second, the impact of this on individuals is a significant deterioration of the working lives of the workers affected. In turn this case study provides a microcosm of the wider consideration of how resilient the notion of the model employer narrative remains in the face of the competing demands of NPM. In summary it can be observed that initiatives aimed at promoting work-life balance for workers, supported by union agreement at high level, can work in some circumstances, but are not resilient when challenged by conflicting financial imperatives – even though the financial case for work-life balance is supported by longer term sustainability linked to the costs of staff burnout, employee retention, reduced sickness absence, reduced stress and reduced inter-personal conflict in the workplace (Rapport *et al*, 2002).

The particular case study in question originated in a project to consider individual workers' work-life balance in healthcare, within the context of a pre-existing framework (IWL). In the spirit of the model employer narrative that has characterised NHS systems in the past, IWL aimed to be an integrative, mutual gains system encouraging managers to reflect on the

continuation of working practices that perpetuate presenteeism enforced by unilateral management decision-making processes that are not in staff, management or patient interests Avgar et al, 2011; Moonesinghe, 2011). This system would be reinforced by the union's national level endorsement of these principles and the assumption that this could be enforced at local workplace-level practices.

In some ways the findings provide explanations as to why the promises made in IWL had been perceived to have been broken (Skinner et al, 2004). What was found in the present study was that the intervention of the upstream (Bach and Kessler, 2012) performance management element of the *Turnaround* policy undermined the intentions of IWL. In particular it was found that short term financial constraints removed the capacity of managers to ensure equitable arrangements around working time: allocation of shift rostering was adjusted, the availability of cover staff was restricted and work intensity increased. Added to this, was the added threat to job security caused by redundancy – as required by *Turnaround* - and the manner in which the *Turnaround* team implemented such initiatives combined to increase stress and the levels of presenteeism in the workplace.

The research identified that whilst there was support for the aims of IWL, it was proving extremely difficult to achieve. We argue that rather than this being any inherent problem of meeting the operational needs of running an acute twenty-four hour service (McBride, 2003), especially for issues such as self-rostering, it was a consequence of the clashing objectives of competing reform initiatives aiming to make staffing more cost effective in line with financial restructuring.

One question that remains is the that of why the unions, at local level, did not feel willing or able to mobilise the narrative of IWL in order to further their members' interests? The answer would seem to be that IWL was not perceived, locally, as a union co-sponsored initiative. The unions were not involved in any local-level IWL activities and the union did not report any member seeking support under the principles of IWL. Most crucially, however, the unions clearly 'had their hands full' in dealing with the issues of forced redundancies and the existential threat of hospital closure. Overall this suggests that national-level jointly sponsored initiatives promoting mutual gains projects- exactly in the spirit of *integrative bargaining* (Walton and McKersie, 1985) – cannot be achieved if there is no local union sponsorship.

The case study makes one final contribution to the understanding of the employment relations system in the NHS. Two broad conceptual approaches could explain the relationship that exists between two competing employment relations sub-systems. The first is that of one system displacing another, led by changing management paradigms adjusting to the relative strength of labour. Barley and Kunda's (1992) assertion that 'normative' and 'rational' management ideologies of control alternate, in line with to long-wave economic cycles is a good example. Similarly Ramsay's (1977) model of waves of management-led worker participation schemes being a response to the relative strength or organised labour.

However, matching the relationship between IWL (within the narrative of the model employer) and *Turnaround* (within the narrative of NPM) within this case study – and therefore in the NHS more generally – does not seem to be sequential. The link between IWL and the model employer is a clear one; the link between *Turnaround* and NPM is

equally clear. Yet if looked at sequentially, the model employer predates NPM; and IWL appears to predate *Turnaround*. While the model employer falls out of fashion during the period when NPM becomes dominant (the 1980s and 1990s) it is never formally repudiated. When IWL was introduced, in 2000, it is not as an antidote to NPM, but as a complementary process. The subsequent use of *Turnaround* is not done with any reference to – or even any acknowledgement of the existence of – IWL. Significantly, all these narratives and policy mechanisms appear to exist simultaneously. It is not, therefore, the case of one *supplanting* another, but of one *dominating* the other. In this sense, the finding is remarkably similar to that of Esbenshade, et al (2016).

Therefore a second broad approach to dealing with the relationship between two parallel – but not complementary management systems is needed. The simplest way of considering this relationship is to consider the NHS employment relations system as dualist one (Tailby, et al, 2004). It would seem that while these parallel systems can coexist, at times of crisis they in conflict with each other and under those circumstances, the integrative model employer narrative is suppressed to meet the imperatives of performance-driven NPM, very much in line with a 'utilitarian instrumentalist' approach to managing human resources within a public service context (Morgan and Allington, 2002).

The analysis of how IWL operated was conceptualised as being a component of the downstream element within the dualist NHS employment relations system (Bach and Kessler, 2012). However, while Bach and Kessler suggest that the upstream and downstream elements of this system are largely complementary – also reflected in the findings of Hyde *et al* (2006), - this study suggests that they were antagonistic in nature and that the downstream IWL was nullified by the financial imperative encapsulated by the

upstream element of *Turnaround*. This was manifested, at the individual level, by the rationing of working time flexibility and the consequent negative spillover of work intensification that spanned the work-family boundary. All of this was introduced by means of imposition, rather than by consent. As a consequence, job design and working patterns created inbuilt barriers, for example to organising childcare to suit working hours. As has been demonstrated elsewhere (Rigby and O'Brien Smith, 2010), pursuing work-life balance needs to go beyond formal human resource management policy and instead deal with the operational reality at the front-line.

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